**91060** Gastric saline load test

(For biopsy by capsule, small intestine, per oral, via tube (one or more specimens), see 44100)

**91065** Breath hydrogen test (eg, for detection of lactase deficiency)

(91090 has been deleted)

**91100** Intestinal bleeding tube, passage, positioning and monitoring

**91105** Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)

(For cholangiography, see 47500, 74320)

(For abdominal paracentesis, see 49080, 49081; with instillation of medication, see 96535)

(For peritoneoscopy, see 56360; with biopsy, see 56361)

(For peritoneoscopy and guided transhepatic cholangiography, see 56362; with biopsy, see 56363)

(For splenoportography, see 38200, 75810)

**91122** Anorectal manometry

**91299** Unlisted diagnostic gastroenterology procedure

# Ophthalmology

## OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

(For surgical procedures, see Surgery, Eye and Ocular Adnexa, 65091 et seq)

DEFINITIONS

INTERMEDIATE OPHTHALMOLOGICAL SERVICES: A level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis.





For example: a. Review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological services. b. Review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services.

COMPREHENSIVE OPHTHALMOLOGICAL SERVICES: A level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated; biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs as indicated.

For example:

The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient.

"Initiation of diagnostic and treatment program" includes the prescription of medication, lenses and other therapy and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services as may be indicated.

Prescription of lenses may be deferred to a subsequent visit, but in any circumstance is not reported separately. ("Prescription of lenses" does not include anatomical facial measurements for or writing of laboratory specifications for spectacles. For Spectacle Services, see 92340 et seq).

SPECIAL OPHTHALMOLOGICAL SERVICES: Services in which a special evaluation of part of the visual system is made, which goes beyond the services usually included under general ophthalmological services, or in which special treatment is given.

For example:

Fluorescein angioscopy, quantitative visual field examination, or extended color vision examination (such as Nagel's anomaloscope) should be specifically reported as special ophthalmological services.

Medical diagnostic evaluation by the physician is an integral part of all ophthalmological services. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, motor evaluation is not applicable.

## GENERAL OPHTHALMOLOGICAL SERVICES

### NEW PATIENT

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

**92002** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

**92004** comprehensive, new patient, one or more visits

### ESTABLISHED PATIENT

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

**92012** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

**92014** comprehensive, established patient, one or more visits

(For surgical procedures, see Surgery, Eye and Ocular Adnexa, 65091 et seq)

## SPECIAL OPHTHALMOLOGICAL SERVICES

**92015** Determination of refractive state

**92018** Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete

**92019** limited





**92020** Gonioscopy with medical diagnostic evaluation (separate procedure)

(For gonioscopy under general anesthesia, see 92018)

**92060** Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation (eg, restrictive or paretic muscle with diplopia) (separate procedure)

**92065** Orthoptic and/or pleoptic training, with continuing medical direction and evaluation

**92070** Fitting of contact lens for treatment of disease, including supply of lens

**92081** Visual field examination, unilateral or bilateral, with medical diagnostic evaluation; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

**92082** intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

**92083** extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 , or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

(Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately)

**92100** Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with medical diagnostic evaluation, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)

**92120** Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method

**92130** Tonography with water provocation

**92140** Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography

## OPHTHALMOSCOPY

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

▲**92225** Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with medical diagnostic evaluation; initial

**92226** subsequent

▲**92230** Fluorescein angioscopy with medical diagnostic evaluation

▲**92235** Fluorescein angiography (includes multiframe imaging) with medical diagnostic evaluation

▲**92250** Fundus photography with medical diagnostic evaluation

▲**92260** Ophthalmodynamometry

(For ophthalmoscopy under general anesthesia, see 92018)

## OTHER SPECIALIZED SERVICES

▲**92265** Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation

**92270** Electro-oculography, with medical diagnostic evaluation

**92275** Electroretinography, with medical diagnostic evaluation

**92280** Visually evoked potential (response) study, with medical diagnostic evaluation

(For electronystagmography for vestibular function studies, see 92541 et seq)

(For ophthalmic echography (diagnostic ultrasound), see 76511-76529)

**92283** Color vision examination, extended, eg, anomaloscope or equivalent

(Color vision testing with pseudoisochromatic plates (such as HRR or Ishihara) is not reported separately. It is included in the appropriate general or ophthalmological service.)

**92284** Dark adaptation examination, with medical diagnostic evaluation



**92285** External ocular photography with medical diagnostic evaluation for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)

**92286** Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count

**92287** with fluorescein angiography

## CONTACT LENS SERVICES

The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services.

The fitting of contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012 et seq).

The supply of contact lenses may be reported as part of the service of fitting. It may also be reported separately by using 92391 or 92396 and modifier '-26' or 09926 for the service of fitting without supply.

(For therapeutic or surgical use of contact lens, see 68340, 92070)

**92310** Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

(For prescription and fitting of one eye, add modifier -52 or 09952)

**92311** corneal lens for aphakia, one eye

**92312** corneal lens for aphakia, both eyes

**92313** corneoscleral lens

**92314** Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia

(For prescription and fitting of one eye, add modifier -52 or 09952)

**92315** corneal lens for aphakia, one eye

**92316** corneal lens for aphakia, both eyes

**92317** corneoscleral lens

**92325** Modification of contact lens (separate procedure), with medical supervision of adaptation

**92326** Replacement of contact lens

### OCULAR PROSTHETICS, ARTIFICIAL EYE

**92330** Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation

(If supply is not included, use modifier -26 or 09926; to report supply separately, see 92393)

**92335** Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation

### SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

Prescription of spectacles, when required, is an integral part of general ophthalmological services and is not reported separately. It includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

Fitting of spectacles is a separate service; when provided by the physician, it is reported as indicated by 92340-92371. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of physician is not required.

Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

**92340** Fitting of spectacles, except for aphakia; monofocal

**92341** bifocal

**92342** multifocal, other than bifocal

**92352** Fitting of spectacle prosthesis for aphakia; monofocal

**92353** multifocal





**92354** Fitting of spectacle mounted low vision aid; single element system

**92355** telescopic or other compound lens system

**92358** Prosthesis service for aphakia, temporary (disposable or loan, including materials)

**92370** Repair and refitting spectacles; except for aphakia

**92371** spectacle prosthesis for aphakia

### SUPPLY OF MATERIALS

**92390** Supply of spectacles, except prosthesis for aphakia and low vision aids

**92391** Supply of contact lenses, except prosthesis for aphakia

(For supply of contact lenses reported as part of the service of fitting, see 92310-92313)

(For replacement of contact lens, see 92326)

**92392** Supply of low vision aids (A low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction. Includes reading additions up to 4D.)

**92393** Supply of ocular prosthesis (artificial eye)

(For supply reported as part of the service of fitting, see 92330)

**92395** Supply of permanent prosthesis for aphakia; spectacles

(For temporary spectacle correction, see 92358)

**92396** contact lenses

(For supply reported as part of the service of fitting, see 92311, 92312)

(See 99070 for the supply of other materials, drugs, trays, etc.)

### OTHER PROCEDURES

**92499** Unlisted ophthalmological service or procedure

**64870** facial-phrenic

**64872** Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy)

**64874** requiring extensive mobilization, or transposition of nerve (list separately in addition to code for nerve suture)

**64876** requiring shortening of bone of extremity (list separately in addition to code for nerve suture)

### NEURORRHAPHY WITH NERVE GRAFT

**64885** Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length

**64886** more than 4 cm in length

**64890** Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length

**64891** more than 4 cm length

**64892** Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length

**64893** more than 4 cm length

**64895** Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length

**64896** more than 4 cm length

**64897** Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length

**64898** more than 4 cm length

**64901** Nerve graft, each additional nerve; single strand

**64902** multiple strands (cable)

**64905** Nerve pedicle transfer; first stage

**64907** second stage

**64999** Unlisted procedure, nervous system

## Eye and Ocular Adnexa

(For diagnostic and treatment ophthalmological services, see medicine, ophthalmology, and 92002 et seq)





### EYEBALL

#### REMOVAL OF EYE

**65091** Evisceration of ocular contents; without implant

**65093** with implant

**65101** Enucleation of eye; without implant

**65103** with implant, muscles not attached to implant

**65105** with implant, muscles attached to implant

(For conjunctivoplasty after enucleation, see 68320 et seq)

**65110** Exenteration of orbit (does not include skin graft), removal of orbital contents; only

**65112** with therapeutic removal of bone

**65114** with muscle or myocutaneous flap

(For skin graft to orbit (split skin), see 15120, 15121; free, full thickness, see 15260, 15261)

(For eyelid repair involving more than skin, see 67930 et seq)

#### SECONDARY IMPLANT PROCEDURES

An ocular implant is an implant inside muscular cone; an orbital implant is an implant outside muscular cone.

**65125** Modification of ocular implant (eg, drilling receptacle for prosthesis appendage) (separate procedure)

**65130** Insertion of ocular implant secondary; after evisceration, in scleral shell

**65135** after enucleation, muscles not attached to implant

**65140** after enucleation, muscles attached to implant

**65150** Reinsertion of ocular implant; with or without conjunctival graft

**65155** with use of foreign material for reinforcement and/or attachment of muscles to implant

**65175** Removal of ocular implant

(For orbital implant (implant outside muscle cone) insertion, see 67550; removal, see 67560)

### REMOVAL OF OCULAR FOREIGN BODY

(For removal of implanted material: ocular implant, see 65175; anterior segment implant, see 65920; posterior segment implant, see 67120; orbital implant, see 67560)

(For diagnostic x-ray for foreign body, see 70030)

(For diagnostic echography for foreign body, see 76529)

(For removal of foreign body from orbit: frontal approach, see 67413; lateral approach, see 67430; transcranial approach, see 61334)

(For removal of foreign body from eyelid, embedded, see 67938)

(For removal of foreign body from lacrimal system, see 68530)

**65205*** Removal of foreign body, external eye; conjunctival superficial

**65210*** conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating

**65220*** corneal, without slit lamp

**65222*** corneal, with slit lamp

(For repair of corneal laceration with foreign body, see 65275)

(65230 has been deleted. To report, use 65235)

**65235** Removal of foreign body, intraocular; from anterior chamber or lens

(65240, 65245 have been deleted. To report, use 65235)

(For removal of implanted material from anterior segment, see 65920)

**65260** from posterior segment, magnetic extraction, anterior or posterior route

**65265** from posterior segment, nonmagnetic extraction

(For removal of implanted material from posterior segment, see 67120)

### REPAIR OF LACERATION OF EYEBALL

(For fracture of orbit, see 21385 et seq)



(For repair of wound of eyelid, skin, linear, simple, see 12011-12018; intermediate, layered closure, see 12051-12057; linear, complex, see 13150-13300; other, see 67930, 67935)

(For repair of wound of lacrimal system, see 68700)

(For repair of operative wound, see 66250)

**65270*** Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure

**65272** conjunctiva, by mobilization and rearrangement, without hospitalization

**65273** conjunctiva, by mobilization and rearrangement, with hospitalization

**65275** cornea, nonperforating, with or without removal foreign body

**65280** cornea and/or sclera, perforating, not involving uveal tissue

**65285** cornea and/or sclera, perforating, with reposition or resection of uveal tissue

**65286** application of tissue glue, wounds of cornea and/or sclera

(Repair of laceration includes use of conjunctival flap and restoration of anterior chamber, by air or saline injection when indicated)

(For repair of iris or ciliary body, see 66680)

**65290** Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

## ANTERIOR SEGMENT—CORNEA

### EXCISION

(65300 has been deleted)

**65400** Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium

**65410*** Biopsy of cornea

**65420** Excision or transposition of pterygium; without graft

**65426** with graft

### REMOVAL OR DESTRUCTION

**65430*** Scraping of cornea, diagnostic, for smear and/or culture

**65435*** Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)

**65436** with application of chelating agent (eg, EDTA)

(65445 has been deleted. To report, use 65450)

**65450** Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization

(65455 has been deleted. To report, use 65450)

▲**65600** Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)

### KERATOPLASTY

(Keratoplasty excludes refractive keratoplasty procedures, 65760, 65765, and 65767)

(Corneal transplant includes use of fresh or preserved grafts, and preparation of donor material)

**65710** Keratoplasty (corneal transplant); lamellar

(65720, 65725 have been deleted. To report, see 65710)

**65730** penetrating (except in aphakia)

(65740, 65745 have been deleted. To report, see 65730)

**65750** penetrating (in aphakia)

**65755** penetrating (in pseudophakia)

### OTHER PROCEDURES

**65760** Keratomileusis

**65765** Keratophakia

**65767** Epikeratoplasty

**65770** Keratoprosthesis

**65771** Radial keratotomy

**65772** Corneal relaxing incision for correction of surgically induced astigmatism





**65775** Corneal wedge resection for correction of surgically induced astigmatism

(For fitting of contact lens for treatment of disease, see 92070)

(For unlisted procedures on cornea, see 66999)

## ANTERIOR SEGMENT—ANTERIOR CHAMBER

### INCISION

**65800*** Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous

**65805*** with therapeutic release of aqueous

**65810** with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection

**65815** with removal of blood, with or without irrigation and/or air injection

(For injection, see 66020-66030)

(For removal of blood clot, see 65930)

**65820** Goniotomy

(65825, 65830 have been deleted)

**65850** Trabeculotomy ab externo

**65855** Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)

(If re-treatment is necessary after several months because of disease progression, a new treatment or treatment series should be reported with a modifier, if necessary, to indicate lesser or greater complexity)

(For trabeculectomy, see 66170)

**65860** Severing adhesions of anterior segment, laser technique (separate procedure)

### OTHER PROCEDURES

**65865** Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae

(For trabeculoplasty by laser surgery, use 65855)

**65870** anterior synechiae, except goniosynechiae

**65875** posterior synechiae

**65880** corneovitreal adhesions

(For laser surgery, use 66821)

**65900** Removal of epithelial downgrowth, anterior chamber eye

**65920** Removal of implanted material, anterior segment eye

**65930** Removal of blood clot, anterior segment eye

**66020** Injection, anterior chamber (separate procedure); air or liquid

**66030*** medication

(For unlisted procedures on anterior segment, see 66999)

## ANTERIOR SEGMENT—ANTERIOR SCLERA

### EXCISION

(For removal of intraocular foreign body, see 65235)

(For operations on posterior sclera, see 67250, 67255)

**66130** Excision of lesion, sclera

**66150** Fistulization of sclera for glaucoma; trephination with iridectomy

**66155** thermocauterization with iridectomy

**66160** sclerectomy with punch or scissors, with iridectomy

**66165** iridencleisis or iridotasis

▲**66170** trabeculectomy ab externo in absence of previous surgery

(For trabeculotomy ab externo, see 65850)

(For repair of operative wound, see 66250)

•**66172** trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)

**66180** Aqueous shunt to extraocular reservoir, (eg, Molteno, Schocket, Denver-Krupin)

**66185** Revision of aqueous shunt to extraocular reservoir





(For removal of implanted shunt, use 67120)

### REPAIR

(For scleral procedures in retinal surgery, see 67101 et seq)

**66220** Repair of scleral staphyloma; without graft

**66225** with graft

(For scleral reinforcement, see 67250, 67255)

### REVISION OPERATIVE WOUND

**66250** Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

### OTHER PROCEDURES

(For unlisted procedures on anterior sclera, see 66999)

## ANTERIOR SEGMENT—IRIS, CILIARY BODY

### IRIDOTOMY, IRIDECTOMY

**66500** Iridotomy by stab incision (separate procedure); except transfixion

**66505** with transfixion as for iris bombe

**66600** Iridectomy, with corneoscleral or corneal section; for removal of lesion

**66605** with cyclectomy

**66625** peripheral for glaucoma (separate procedure)

**66630** sector for glaucoma (separate procedure)

**66635** "optical" (separate procedure)

(For "iridotomy" by photocoagulation, see 66761)

(For "coreoplasty" by photocoagulation, see 66762)

### REPAIR

**66680** Repair of iris, ciliary body (as for iridodialysis)

(For reposition or resection of uveal tissue with perforating wound of cornea or sclera, see 65285)

**66682** Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

### DESTRUCTION

**66700** Ciliary body destruction; diathermy

(66701, 66702, 66721, 66741 have been deleted. To report, see 66700, 66710, 66720, 66740)

**66710** cyclophotocoagulation

**66720** cryotherapy

**66740** cyclodialysis

**66761** Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)

**66762** Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle)

**66770** Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

(For excision lesion iris, ciliary body, see 66600, 66605; for removal epithelial downgrowth, see 65900)

### OTHER PROCEDURES

(For unlisted procedures on iris, ciliary body, see 66999)

## ANTERIOR SEGMENT—LENS

### INCISION

(66800, 66801 have been deleted. To report, use 66999)

(66802 has been deleted)

**66820** Discission of secondary membraneous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)

**66821** laser surgery (eg, YAG laser) (one or more stages)

**66825** Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)

### REMOVAL CATARACT

Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, use of other pharmacologic agents, and subconjunctival or sub-tenon injections are included as part of the code for the extraction of lens.





**66830** Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)

**66840** Removal of lens material; aspiration technique, one or more stages

**66850** phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration

**66852** pars plana approach, with or without vitrectomy

(66915 has been deleted)

**66920** intracapsular

**66930** intracapsular, for dislocated lens

**66940** extracapsular (other than 66840, 66850, 66852)

(66945 has been deleted. To report, see 66920-66940)

(For removal of intralenticular foreign body without lens extraction, see 65235)

(For repair of operative wound, see 66250)

(66980 has been deleted. To report, see 66983, 66984)

**66983** Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

**66984** Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

**66985** Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal

(To code implant at time of concurrent cataract surgery, use 66983 or 66984)

(For intraocular lens prosthesis supplied by physician, use 99070)

(For ultrasonic determination of intraocular lens power, use 76519)

(For removal of implanted material from anterior segment, use 65920)

(For secondary fixation (separate procedure), use 66682)

**66986** Exchange of intraocular lens

**66999** Unlisted procedure, anterior segment of eye

## POSTERIOR SEGMENT—VITREOUS

**67005** Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal

**67010** subtotal removal with mechanical vitrectomy

(For removal of vitreous by paracentesis of anterior chamber, see 65810)

(For removal of corneovitreal adhesions, see 65880)

**67015** Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)

**67025** Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)

**67028** Intravitreal injection of a pharmacologic agent (separate procedure)

**67030** Discission of vitreous strands (without removal), pars plana approach

**67031** Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)

(67035 has been deleted. To report, use 67036)

**67036** Vitrectomy, mechanical, pars plana approach;

**67038** with epiretinal membrane stripping

**67039** with focal endolaser photocoagulation

**67040** with endolaser panretinal photocoagulation

(For associated lensectomy, see 66850)

(For use of vitrectomy in retinal detachment surgery, see 67108)

(For associated removal of foreign body, see 65260, 65265)

(For unlisted procedures on vitreous, see 67299)





## POSTERIOR SEGMENT—RETINAL DETACHMENT

### REPAIR

(If diathermy, cryotherapy and/or photocoagulation are combined, report under principal modality used)

**67101** Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid

(67102, 67103 have been deleted. To report, use 67101)

(67104 has been deleted. To report, use 67105)

**67105** photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid

(67106 has been deleted. To report, use 67105)

**67107** scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant, may include procedures 67101, 67105

**67108** with vitrectomy, any method, with or without air or gas tamponade, with or without focal endolaser photocoagulation, may include procedures 67101-67107 and/or removal of lens by same technique

**67109** by technique other than 67101-67108 and 67110

▲**67110** by injection of air or other gas (eg, pneumatic retinopexy)

**67112** previously operated upon, any technique

(For aspiration or drainage of subretinal or subchoroidal fluid, see 67015)

**67115** Release of encircling material (posterior segment)

**67120** Removal of implanted material, posterior segment; extraocular

**67121** intraocular

(For removal from anterior segment, use 65920)

(For removal of foreign body, see 65260, 65265)

### PROPHYLAXIS

Repetitive services. The services listed below are often performed in multiple sessions or groups of sessions. The methods of reporting vary. The following descriptors are intended to include all sessions in a defined treatment period.

**67141** Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy

(67142, 67143 have been deleted. To report, use 67141)

(67144 has been deleted. To report, use 67145)

**67145** photocoagulation (laser or xenon arc)

(67146 has been deleted. To report, use 67145)

## POSTERIOR SEGMENT—OTHER PROCEDURES

### DESTRUCTION—RETINA, CHOROID

**67208** Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy

**67210** photocoagulation (laser or xenon arc)

(67212, 67213 have been deleted. To report, use 67208)

(67214, 67216 have been deleted. To report, use 67210)

**67218** radiation by implantation of source (includes removal of source)

(67222, 67223 have been deleted. To report, use 67227)

(67224, 67226 have been deleted. To report, use 67228)

**67227** Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy

**67228** photocoagulation (laser or xenon arc)

(For unlisted procedures on retina, see 67299)

### SCLERAL REPAIR

(For excision lesion sclera, see 66130)

**67250** Scleral reinforcement (separate procedure); without graft

**67255** with graft

(For repair scleral staphyloma, see 66220, 66225)

**67299** Unlisted procedure, posterior segment





## OCULAR ADNEXA—EXTRAOCULAR MUSCLES

**67311** Strabismus surgery, recession or resection procedure (patient not previously operated on); one horizontal muscle

**67312** two horizontal muscles

(67313 has been deleted)

**67314** one vertical muscle (excluding superior oblique)

**67316** two or more vertical muscles (excluding superior oblique)

(For adjustable sutures, use 67335 in addition to primary procedure reflecting number of muscles operated on)

**67318** Strabismus surgery, any procedure (patient not previously operated on), superior oblique muscle

(Use 67320, 67331, 67332, 67335, 67340, 67343 in addition to code for primary strabismus surgery (67311-67318))

**67320** Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)

**67331** Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles

**67332** Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)

**67334** Strabismus surgery by posterior fixation suture technique, with or without muscle recession

**67335** Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (Report in addition to code for specific strabismus surgery)

(Use also code for conventional muscle surgery, 67311-67334, to identify number of muscles involved)

**67340** Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)

**67343** Release of extensive scar tissue without detaching extraocular muscle (separate procedure)

**67345** Chemodenervation of extraocular muscle

(For chemodenervation for blepharospasm and other neurological disorders, see 64612 and 64613)

### OTHER PROCEDURES

**67350** Biopsy of extraocular muscle

(For repair of wound, extraocular muscle, tendon or Tenon's capsule, see 65290)

**67399** Unlisted procedure, ocular muscle

## OCULAR ADNEXA—ORBIT

### EXPLORATION, EXCISION, DECOMPRESSION

**67400** Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without bone biopsy

**67405** with drainage only

**67412** with removal of lesion

**67413** with removal of foreign body

**67414** with removal of bone for decompression

**67415** Fine needle aspiration of orbital contents

(For exenteration, enucleation, and repair, see 65101 et seq; for optic nerve decompression, see 67570)

**67420** Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion

**67430** with removal of foreign body

**67440** with drainage

**67445** with removal of bone for decompression

(For optic nerve sheath decompression, see 67570)

**67450** for exploration, with or without biopsy

(For orbitotomy, transcranial approach, see 61330-61334)

(For orbital implant, see 67550, 67560)

(For removal of eyeball or for repair after removal, see 65091-65175)





### OTHER PROCEDURES

**67500*** Retrobulbar injection; medication (separate procedure, does not include supply of medication)

**67505** alcohol

(67510 has been deleted. To report, use 67599)

**67515*** Injection of therapeutic agent into Tenon's capsule

(For subconjunctival injection, see 68200)

**67550** Orbital implant (implant outside muscle cone); insertion

**67560** removal or revision

(For ocular implant (implant inside muscle cone), see 65093-65105, 65130-65175)

(For treatment of fractures of malar area, orbit, see 21355 et seq)

**67570** Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)

**67599** Unlisted procedure, orbit

## OCULAR ADNEXA—EYELIDS

### INCISION

**67700*** Blepharotomy, drainage of abscess, eyelid

**67710*** Severing of tarsorrhaphy

**67715*** Canthotomy (separate procedure)

(For canthoplasty, see 67950)

(For division of symblepharon, see 68340)

### EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (ie, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

(For removal of lesion, involving mainly skin of eyelid, see 11440-11446; 11640-11646; 17000-17010)

(For repair of wounds, blepharoplasty, grafts, reconstructive surgery, see 67930-67975)

**67800** Excision of chalazion; single

**67801** multiple, same lid

**67805** multiple, different lids

**67808** under general anesthesia and/or requiring hospitalization, single or multiple

**67810*** Biopsy of eyelid

**67820*** Correction of trichiasis; epilation, by forceps only

**67825*** epilation, (eg, by electrosurgery or cryotherapy)

**67830** incision of lid margin

**67835** incision of lid margin, with free mucous membrane graft

**67840*** Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

(For excision and repair of eyelid by reconstructive surgery, see 67961, 67966)

**67850*** Destruction of lesion of lid margin (up to 1 cm)

(For Mohs' micrographic surgery, see 17304-17310)

(For initiation or follow-up care of topical chemotherapy (eg, 5-FU or similar agents), see appropriate office visits)

### TARSORRHAPHY

**67875** Temporary closure of eyelids by suture (eg, Frost suture)

**67880** Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;

**67882** with transposition of tarsal plate

(For severing of tarsorrhaphy, see 67710)

(For canthoplasty, reconstruction canthus, see 67950)

(For canthotomy, see 67715)

### REPAIR OF BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION

**67900** Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

(For forehead rhytidectomy, see 15824)

**67901** Repair of blepharoptosis; frontalis muscle technique with suture or other material





**67902** frontalis muscle technique with fascial sling (includes obtaining fascia)

**67903** (tarso)levator resection or advancement, internal approach

**67904** (tarso)levator resection or advancement, external approach

**67906** superior rectus technique with fascial sling (includes obtaining fascia)

(67907 has been deleted. To report, use 67999)

**67908** conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)

**67909** Reduction of overcorrection of ptosis

**67911** Correction of lid retraction

(For obtaining autogenous graft materials, see 20920, 20922 or 20926)

### REPAIR ECTROPION, ENTROPION

(For correction trichiasis by mucous membrane graft, see 67835)

**67914** Repair of ectropion; suture

**67915** thermocauterization

**67916** blepharoplasty, excision tarsal wedge

**67917** blepharoplasty, extensive (eg, Kuhnt-Szymanowski or tarsal strip operations)

(For correction of everted punctum, see 68705)

**67921** Repair of entropion; suture

**67922** thermocauterization

**67923** blepharoplasty, excision tarsal wedge

**67924** blepharoplasty, extensive (eg, Wheeler operation)

(For repair of cicatricial ectropion or entropion requiring scar excision or skin graft, see also 67961 et seq)

### RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (ie, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

**67930** Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial thickness

**67935** full thickness

**67938** Removal of embedded foreign body, eyelid

(For repair of skin of eyelid, see 12011-12018; 12051-12057; 13150, 13152, 13300)

(For tarsorrhaphy, canthorrhaphy, see 67880, 67882)

(For repair of blepharoptosis and lid retraction, see 67901-67911)

(For blepharoplasty for entropion, ectropion, see 67916, 67917, 67923, 67924)

(For correction of blepharochalasis (blepharorhytidectomy), see 15820-15823)

(For repair of skin of eyelid, adjacent tissue transfer, see 14060, 14061; preparation for graft, see 15000; free graft, see 15120, 15121, 15260, 15261)

(For excision of lesion of eyelid, see 67800 et seq)

(For repair of lacrimal canaliculi, see 68700)

**67950** Canthoplasty (reconstruction of canthus)

**67961** Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin

**67966** over one-fourth of lid margin

(For canthoplasty, see 67950)

(For free skin grafts, see 15120, 15121, 15260, 15261)

(For tubed pedicle flap preparation, see 15576; for delay, see 15630; for attachment, see 15630)





**67971** Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage

**67973** total eyelid, lower, one stage or first stage

**67974** total eyelid, upper, one stage or first stage

**67975** second stage

### OTHER PROCEDURES

**67999** Unlisted procedure, eyelids

## OCULAR ADNEXA—CONJUNCTIVA

(For removal of foreign body, see 65205 et seq)

### INCISION, DRAINAGE

**68020** Incision of conjunctiva, drainage of cyst

**68040** Expression of conjunctival follicles, eg, for trachoma

### EXCISION, DESTRUCTION

**68100** Biopsy of conjunctiva

**68110** Excision of lesion, conjunctiva; up to 1 cm

**68115** over 1 cm

**68130** with adjacent sclera

**68135*** Destruction of lesion, conjunctiva

### INJECTION

(For injection into Tenon's capsule or retrobulbar injection, see 67500-67515)

**68200*** Subconjunctival injection

### CONJUNCTIVOPLASTY

(For wound repair, see 65270-65273)

**68320** Conjunctivoplasty; with conjunctival graft or extensive rearrangement

**68325** with buccal mucous membrane graft (includes obtaining graft)

**68326** Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement

**68328** with buccal mucous membrane graft (includes obtaining graft)

**68330** Repair of symblepharon; conjunctivoplasty, without graft

**68335** with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)

**68340** division of symblepharon, with or without insertion of conformer or contact lens

### OTHER PROCEDURES

**68360** Conjunctival flap; bridge or partial (separate procedure)

**68362** total (such as Gunderson thin flap or purse string flap)

(For conjunctival flap for perforating injury, see 65280, 65285)

(For repair of operative wound, see 66250)

(For removal of conjunctival foreign body, see 65205, 65210)

**68399** Unlisted procedure, conjunctiva

## OCULAR ADNEXA—LACRIMAL SYSTEM

### INCISION

**68400** Incision, drainage of lacrimal gland

**68420** Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)

**68440*** Snip incision of lacrimal punctum

### EXCISION

**68500** Excision of lacrimal gland (dacryoadenectomy), except for tumor; total

**68505** partial

**68510** Biopsy of lacrimal gland

**68520** Excision of lacrimal sac (dacryocystectomy)

**68525** Biopsy of lacrimal sac

**68530** Removal of foreign body or dacryolith, lacrimal passages

**68540** Excision of lacrimal gland tumor; frontal approach

**68550** involving osteotomy





### REPAIR

**68700** Plastic repair of canaliculi

**68705** Correction of everted punctum, cautery

**68720** Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)

**68745** Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube

**68750** with insertion of tube or stent

**68760** Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery

**68761** by plug, each

**68770** Closure of lacrimal fistula (separate procedure)

### PROBING AND RELATED PROCEDURES

**68800*** Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral

**68820*** Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral;

**68825** requiring general anesthesia

(See also 92018)

**68830** with insertion of tube or stent

**68840*** Probing of lacrimal canaliculi, with or without irrigation

**68850*** Injection of contrast medium for dacryocystography

(For radiological supervision and interpretation, see 70170)

### OTHER PROCEDURES

**68899** Unlisted procedure, lacrimal system

**76090** Mammography; unilateral

**76091** bilateral

**76092** Screening mammography, bilateral (two view film study of each breast)

● **76095** Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation

(For procedure, see 19100, 88170)

**76096** Preoperative placement of needle localization wire, breast, radiological supervision and interpretation

(For placement, see 19290, 19291)

(76097 has been deleted. To report, see 19291, 76096)

▲ **76098** Radiological examination, surgical specimen

**76100** Radiologic examination, single plane body section (eg, tomography), other than with urography

**76101** Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral

**76102** bilateral

(For nephrotomography, see 74415)

**76120** Cineradiography, except where specifically included

**76125** Cineradiography to complement routine examination

(76127 has been deleted. The use of photographic media is not reported separately but is considered to be a component of the basic procedure)

(76130-76137 have been deleted. To report, use code for specific radiologic examination)

**76140** Consultation on x-ray examination made elsewhere, written report

**76150** Xeroradiography

(76150 is to be used for non-mammographic studies only)

(76300 has been deleted. To report, use 76499)





**76350** Subtraction in conjunction with contrast studies

**76355** Computerized tomography guidance for stereotactic localization

**76360** Computerized tomography guidance for needle biopsy, radiological supervision and interpretation

(76361 (complete procedure) has been deleted, see appropriate organ or site and 76360)

**76365** Computerized tomography guidance for cyst aspiration, radiological supervision and interpretation

(76366 (complete procedure) has been deleted, see appropriate organ or site and 76365)

**76370** Computerized tomography guidance for placement of radiation therapy fields

**76375** Computerized tomography, coronal, sagittal, multiplanar, oblique and/or 3- dimensional reconstruction

**76380** Computerized tomography, limited or localized follow-up study

**76400** Magnetic resonance (eg, proton) imaging, bone marrow blood supply

**76499** Unlisted diagnostic radiologic procedure

## Diagnostic Ultrasound

A-mode: Implies a one-dimensional ultrasonic measurement procedure.

M-mode: Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

B-scan: Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Real-time scan: Implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

### HEAD AND NECK

(76500, 76505 have been deleted. To report, use 76999)

**76506** Echoencephalography, B-scan and/or real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated

**76511** Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification

**76512** contact B-scan (with or without simultaneous A-scan)

**76513** immersion (water bath) B-scan

(76515 has been deleted. To report, use 76999)

**76516** Ophthalmic biometry by ultrasound echography, A-scan;

(76517 has been deleted. To report, use 76999)

**76519** with intraocular lens power calculation

**76529** Ophthalmic ultrasonic foreign body localization

(76530 has been deleted. To report, use 76999)

(76535 has been deleted. To report, use 76536)

**76536** Echography, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation

(76550 has been deleted. To report, see 93880-93888)

## CHEST

(76601 has been deleted. To report, use 76999)

**76604** Echography, chest, B-scan (includes mediastinum) and/or real time with image documentation

(76620, 76625 have been deleted)

(76627, 76628 have been deleted. To report, see 93307, 93308)

(76629 has been deleted)

(76632 has been deleted. To report, see 93320, 93321)

(76640 has been deleted. To report, use 76999)

**76645** Echography, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation





## ABDOMEN AND RETROPERITONEUM

**76700** Echography, abdominal, B-scan and/or real time with image documentation; complete

**76705** limited (eg, single organ, quadrant, follow-up)

**76770** Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete

**76775** limited

**76778** Echography of transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler studies

## SPINAL CANAL

**76800** Echography, spinal canal and contents

## PELVIS

**76805** Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)

**76810** complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester

**76815** limited (gestational age, heart beat, placental location, fetal position, or emergency in the delivery room)

**76816** follow-up or repeat

**76818** Fetal biophysical profile

**76825** Echocardiography, fetal, cardiovascular system, real time with image documentation (2D) with or without M-mode recording;

**76826** follow-up or repeat study

**76827** Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; complete

**76828** follow-up or repeat study

(To report the use of color mapping, see 93325)

**76830** Echography, transvaginal

(76855 has been deleted. To report, see 93975-93979)

Both CPT computer tapes are identical technically, each having the following line specifications:

| | |
|---|---|
| record format | fixed |
| logical record length | 80 bytes |
| block size | 80 bytes |
| label | no label |
| tracks | 9 |
| tape density | 1600 or 6250 BPI |
| content | EBCDIC or ASCII |

**CPT Floppy Disk** is identical in content to the short description tape. That is, each code and description is limited to 28 characters or less on a single line.

### Technical Description of Disk

- Standard PC format with a maximum length of 36 characters per record
- Content: ASCII
- PC requirements: IBM PC, XT, AT or compatible
- 3½″ double side/double density (720K) disk OR 5¼″ double side/double density (360K) disk

### Using Compatible Software

Please bear in mind that the disks and tapes contain *only* a CPT data file. They are *not* programs or other operations software. We have deliberately not included programs with this data file, as each user has different needs.

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Department of Coding and Nomenclature
CPT Magnetic Computer Tapes
American Medical Association
515 N. State Street
Chicago, Illinois 60610

# Evaluation and Management (E/M) Services

## Guidelines

In addition to the information presented in the **INTRODUCTION,** several other items unique to this section are defined or identified here:

1. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on pages 5-7.)

2. **DEFINITIONS OF COMMONLY USED TERMS:** Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

**NEW AND ESTABLISHED PATIENT:** A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

**CONCURRENT CARE** is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Modifier '-75' has been deleted.

**COUNSELING** is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

(For psychotherapy, see 90841-90857)

Evaluation and Management Services Guidelines

**LEVELS OF E/M SERVICES:** Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services. (See 7. c., page 11.)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail following (see pages 5-7).

The actual performance of diagnostic tests/studies for which specific CPT codes are available is **not** included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available should be reported separately, *in addition* to the appropriate E/M code.

**NATURE OF PRESENTING PROBLEM:** A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal—A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- Self-limited or Minor—A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity—A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity—A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity—A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.





**TIME:** The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of CPT. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work". It has been demonstrated that physicians' estimations of **intra-service time** (as explained below), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intra-service time and total time for E/M services. Intra-service time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

a. **Face-to-face time (office and other outpatient visits and office consultations):** For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This *non* face-to-face time for office services—also called pre- and post-encounter time—is not included in the time component described in the E/M codes. However, the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

b. **Unit/floor time (hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

Evaluation and Management Services Guidelines

3. **UNLISTED SERVICE:** An E/M service may be provided that is not listed in this section of CPT. When reporting such a service, the appropriate "Unlisted" code may be used to indicate the service, identifying it by "Special Report" as discussed in item 4. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

| | |
|---|---|
| 99429 | Unlisted preventive medicine service |
| 99499 | Unlisted evaluation and management service |

4. **SPECIAL REPORT:** An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

5. **CLINICAL EXAMPLES** of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code. Each example was developed by physicians in the specialties shown.

The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

The examples have been tested for validity and approved by the CPT Editorial Panel. Physicians were given the examples and asked to assign a code or assess the amount of time and work involved. Only those examples that were rated consistently have been included.

6. **MODIFIERS:** Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. Or, the modifier may be reported by a separate five digit code that is used in addition to the procedure code. Modifiers available in E/M are as follows:

   -21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of E/M service within a given category, it may be identified by adding modifier '-21' to the E/M code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

   -24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier '-24' to the appropriate level of E/M service, or the separate five digit modifier 09924 may be used.

   -25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used.
   NOTE: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier '-57'.



   -32 Mandated Services: Services related to *mandated* consultation and/or related services (eg, PRO, 3rd party payor) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

   -52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier '-52.'

   -57 Decision for Surgery. An evaluation and management service that resulted in the initial decision to perform the surgery, may be identified by adding the modifier '-57' to the appropriate level of E/M service, or the separate five digit modifier 09957 may be used.

7. **INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:**

   a. **Identify the category and subcategory of service:** The categories and subcategories of codes available for reporting E/M services are as follows:

| Category/Subcategory | Code Numbers |
|---|---|
| Office or Other Outpatient Services | |
| New Patient | 99201-99205 |
| Established Patient | 99211-99215 |
| Hospital Observation Services | 99218-99220 |
| Hospital Observation Discharge Services | 99217 |
| Hospital Inpatient Services | |
| Initial Hospital Care | 99221-99223 |
| Subsequent Hospital Care | 99231-99233 |
| Hospital Discharge Services | 99238 |
| Consultations | |
| Office Consultations | 99241-99245 |
| Initial Inpatient Consultations | 99251-99255 |
| Follow-up Inpatient Consultations | 99261-99263 |
| Confirmatory Consultations | 99271-99275 |

| Category/Subcategory | Code Numbers |
|---|---|
| Emergency Department Services | 99281-99288 |
| Critical Care Services | 99291-99292 |
| Neonatal Intensive Care | 99295-99297 |
| Nursing Facility Services | |
| Comprehensive Nursing Facility Assessments | 99301-99303 |
| Subsequent Nursing Facility Care | 99311-99313 |
| Domiciliary, Rest Home or Custodial Care Services | |
| New Patient | 99321-99323 |
| Established Patient | 99331-99333 |
| Home Services | |
| New Patient | 99341-99343 |
| Established Patient | 99351-99353 |
| Prolonged Services | |
| With Direct Patient Contact | 99354-99357 |
| Without Direct Patient Contact | 99358-99359 |
| Standby Services | 99360 |
| Case Management Services | |
| Team Conferences | 99361-99362 |
| Telephone Calls | 99371-99373 |
| Care Plan Oversight Services | 99375-99376 |
| Preventive Medicine Services | |
| New Patient | 99381-99387 |
| Established Patient | 99391-99397 |
| Individual Counseling | 99401-99404 |
| Group Counseling | 99411-99412 |
| Other | 99420-99429 |
| Newborn Care | 99431-99440 |
| Other E/M Services | 99499 |

b. **Review the reporting instructions for the selected category or subcategory**: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Inpatient Hospital Care", special instructions will be presented preceding the levels of E/M services.





c. **Review the level of E/M service descriptors and examples in the selected category or subcategory:** The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (ie, history, examination and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See g. 3, page 14.)

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

d. **Determine the extent of HISTORY obtained:** The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused—chief complaint; brief history of present illness or problem.
- Expanded Problem Focused—chief complaint; brief history of present illness; problem pertinent system review.
- Detailed—chief complaint; extended history of present illness; extended system review; **pertinent** past, family and/or social history.
- Comprehensive—chief complaint; extended history of present illness; complete system review; **complete** past, family and social history.

e. **Determine the extent of EXAMINATION performed:** The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused—an examination that is limited to the affected body area or organ system.
- Expanded Problem Focused—an examination of the affected body area or organ system and other symptomatic or related organ systems.
- Detailed—an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive—a complete single system specialty examination or a complete multi-system examination.

f. **Determine the complexity of MEDICAL DECISION MAKING:** Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problems(s), the diagnostic procedure(s) and/or the possible management options.





Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and, high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded:

| Number of diagnoses or management options | Amount and/or complexity of data to be reviewed | Risk of complications and/or morbidity or mortality | Type of decision making |
|---|---|---|---|
| minimal | minimal or none | minimal | **straight-forward** |
| limited | limited | low | **low complexity** |
| multiple | moderate | moderate | **moderate complexity** |
| extensive | extensive | high | **high complexity** |

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision making.

g. **Select the appropriate level of E/M services based on the following:**

1. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

2. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3. In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

# EVALUATION AND MANAGEMENT

## Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 26) or comprehensive nursing facility assessments (pages 52-53).

For services provided by physicians in the Emergency Department, see 99281-99285.

For observation care, see 99217-99220.

For definitions of key components, see Evaluation and Management Services Guidelines.

### NEW PATIENT

**99201** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

### Examples

Initial office visit with 65-year-old male for reassurance about an isolated seborrheic keratosis on the upper back. (Dermatology/ Plastic Surgery)

Initial office visit with 10-year-old male with severe rash and itching for the past 24 hours, positive history for contact with poison oak 48 hours prior to the visit. (Family Medicine)

Initial office visit with 5-year-old female to remove sutures from simple wound, placed by another physician. (Plastic Surgery)

Initial office visit for the evaluation and management of a contusion of a finger. (Orthopaedic Surgery)

Initial office visit with an out-of-town visitor who needs a prescription refilled because she forgot her hay fever medication. (Allergy & Immunology/Internal Medicine)

Initial office visit with 9-month-old female with diaper rash. (Pediatrics)

Initial office visit to advise for or against the removal of wisdom teeth, 18-year-old male referred by an orthodontist. (Oral & Maxillofacial Surgery)

Initial office visit for a 22-year-old male with a small area of sunburn requiring first aid. (Dermatology/Family Medicine/ Internal Medicine)

**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

### Examples

Initial office evaluation for gradual hearing loss, 58-year-old male, history and physical examination, with interpretation of complete audiogram, air bone, etc. (Otolaryngology)

Initial office visit for a 25-year-old patient with single season allergic rhinitis. (Allergy & Immunology)

Initial office visit for a patient with recurring episodes of herpes simplex who has developed a clustering of vesicles on the upper lip. (Internal Medicine)

Initial office visit to plan transient dialysis for a 56-year-old stable dialysis patient who has accompanying records. (Nephrology)





Initial office visit with 10-year-old girl with history of chronic otitis media and a draining ear. (Pediatrics)

Initial office visit, 16-year-old male with severe cystic acne, new patient. (Dermatology)

Initial office visit for a 10-year-old female with acute maxillary sinusitis. (Family Medicine)

Initial evaluation and management of recurrent urinary infection in female. (Internal Medicine)

**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

### Examples

Initial office visit for initial evaluation of a 48-year-old man with recurrent low back pain radiating to the leg. (General Surgery)

Initial office visit for evaluation, diagnosis and management of painless gross hematuria in new patient, without cystoscopy. (Internal Medicine)

Initial office visit for 21-year-old female desiring counseling and evaluation of initiation of contraception. (Family Practice/ Internal Medicine/Obstetrics & Gynecology)

Initial office visit for 49-year-old male presenting with painless blood per rectum associated with bowel movement. (Colon & Rectal Surgery)

Initial office visit with couple for counseling concerning voluntary vasectomy for sterility. Spent 30 minutes discussing procedure, risks and benefits, and answering questions. (Urology)

Initial office visit of 49-year-old male with nasal obstruction. Detailed exam with topical anesthesia. (Plastic Surgery)

Initial office visit for evaluation of 13-year-old female with progressive scoliosis. (Physical Medicine & Rehabilitation)

Initial office visit for 19-year-old football player with 3 day old acute knee injury; now with swelling and pain. (Orthopaedic Surgery)

**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

### Examples

Initial office visit for initial evaluation of a 63-year-old male with chest pain on exertion. (Cardiology/Internal Medicine)

Initial office visit for 7-year-old female with juvenile diabetes mellitus, new to area, past history of hospitalization times three. (Pediatrics)

Initial office visit for a patient with papulosquamous eruption involving 60% of the cutaneous surface with joint pain. Combinations of topical and systemic treatments discussed. (Dermatology)

Initial office visit for evaluation of a 70-year-old patient with recent onset of episodic confusion. (Internal Medicine)

Initial office visit of a 50-year-old female with progressive solid food dysphagia. (Gastroenterology)

Initial office visit for 34-year-old patient with primary infertility, including counseling. (Obstetrics & Gynecology)

Initial office visit for evaluation of 70-year-old female with polyarthralgia. (Rheumatology)

**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.





### Examples

Initial office visit for a 24-year-old homosexual male who has a fever, a cough, and shortness of breath. (Infectious Disease)

Initial office evaluation, patient with systemic lupus erythematosus, fever, seizures and profound thrombocytopenia. (Allergy & Immunology/Internal Medicine/Rheumatology)

Initial office visit for a 17-year-old female, who is having school problems and has told a friend she is considering suicide. The patient and her family are consulted in regards to treatment options. (Psychiatry)

Initial office visit for a 42-year-old male on hypertensive medication, newly arrived to the area, with diastolic blood pressure of 110, history of recurrent renal calculi, episodic headaches, intermittent chest pain and orthopnea. (Internal Medicine)

Initial office visit for a 73-year-old male with an unexplained 20 lb. weight loss. (Hematology/Oncology)

Initial office evaluation and management of patient with systemic vasculitis and compromised circulation to the limbs. (Rheumatology)

Initial office evaluation of a 65-year-old female with exertional chest pain, intermittent claudication, syncope and a murmur of aortic stenosis. (Cardiology)

Initial outpatient evaluation of a 69-year-old male with severe chronic obstructive pulmonary disease, congestive heart failure, and hypertension. (Family Medicine)

Initial office visit for a female with severe hirsutism, amenorrhea, weight loss and a desire to have children. (Endocrinology/Obstetrics & Gynecology)

## ESTABLISHED PATIENT

**99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

### Examples

Outpatient visit with 19-year-old male, established patient, for supervised drug screen. (Addiction Medicine)

Office visit with 31-year-old female, established patient, for return to work certificate. (Anesthesiology)

Office visit for a 45-year-old female, established patient, for a blood pressure check. (Obstetrics & Gynecology)

Office visit with 12-year-old male, established patient, for cursory check of hematoma one day after venipuncture. (Internal Medicine)

Office visit for a 42-year-old established patient to read tuberculin test results. (Allergy & Immunology)

Office visit for 14-year-old established patient to re-dress an abrasion. (Orthopaedic Surgery)

Office visit for prescription refill for a 35-year-old female, established patient, with schizophrenia who is stable but has run out of neuroleptic and is scheduled to be seen in a week. (Psychiatry)

Office visit for a 23-year-old established patient for instruction in use of peak flow meter. (Allergy & Immunology)

**99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a problem focused history;**
- **a problem focused examination;**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

### Examples

Office visit, established patient, 6-year-old child with sore throat and headache. (Family Medicine/Pediatrics)

Office evaluation for possible purulent bacterial conjunctivitis with 1-2 day history of redness and discharge, 16-year-old female, established patient. (Pediatrics/Internal Medicine/ Family Medicine)

Office visit, sore throat, fever and fatigue in 19-year-old college student, established patient. (Internal Medicine)

Office visit for a 65-year-old male, established patient, with eruptions on both arms from poison oak exposure. (Allergy & Immunology/ Internal Medicine)

Office visit with 65-year-old female, established patient, returns for 3 week follow-up for resolving severe ankle sprain. (Orthopaedic Surgery)

Office visit with 33-year-old female, established patient, recently started on treatment for hemorrhoidal complaints, for re-evaluation. (Colon & Rectal Surgery)

Office visit with 36-year-old male, established patient, for follow-up on effectiveness of medicine management of oral candidiasis. (Oral & Maxillofacial Surgery)

Office visit for 27-year-old female, established patient, with complaints of vaginal itching. (Obstetrics & Gynecology)

**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:





- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making of low complexity.**

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

### Examples

Outpatient visit with 37-year-old male, established patient, who is 3 years post total colectomy for chronic ulcerative colitis, presents for increased irritation at his stoma. (General Surgery)

Office visit with 55-year-old male, established patient, for management of hypertension, mild fatigue, on beta blocker/thiazide regimen. (Family Medicine/Internal Medicine)

Office visit for a 70-year-old diabetic hypertensive established patient with recent change in insulin requirement. (Internal Medicine/Nephrology)

Quarterly follow-up office visit for a 45-year-old male established patient, with stable chronic asthma, on steroid and bronchodilator therapy. (Pulmonary Medicine)

Routine, follow-up office evaluation at a three-month interval for a 77-year-old female, established patient, with nodular small cleaved-cell lymphoma. (Hematology/Oncology)

Office visit with 80-year-old female established patient, for follow-up osteoporosis, status-post compression fractures. (Rheumatology)

Office visit for an established patient with stable cirrhosis of the liver. (Gastroenterology)

Office visit for a 50-year-old female, established patient, with insulin-dependent diabetes mellitus and stable coronary artery disease, for monitoring. (Family Medicine/Internal Medicine)

**99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a detailed history;**
- **a detailed examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

### Examples

Office visit for a 68-year-old male, established patient, with stable angina, two months post myocardial infarction, who is not tolerating one of his medications. (Cardiology)

Office visit for 60-year-old male, established patient, 2 years post-removal of intracranial meningioma, now with new headaches and visual disturbance. (Neurosurgery)

Office evaluation of 28-year-old established patient with regional enteritis, diarrhea and low grade fever. (Family Medicine/Internal Medicine)

Follow-up office visit for a 45-year-old established patient with rheumatoid arthritis on gold, methotrexate, or immunosuppressive therapy. (Rheumatology)

Office visit for a 68-year-old female, established patient, for routine review and follow-up of non-insulin dependent diabetes, obesity, hypertension and congestive heart failure. Complains of vision difficulties and admits dietary noncompliance. Patient is counseled concerning diet and current medications adjusted. (Family Medicine)

Weekly office visit for 5FU therapy for an ambulatory established patient with metastatic colon cancer and increasing shortness of breath. (Hematology/Oncology)

Office visit with 50-year-old female, established patient, diabetic, blood sugar controlled by diet. She now complains of frequency of urination and weight loss, blood sugar of 320 and negative ketones on dipstick. (Internal Medicine)

Office evaluation on new onset RLQ pain in a 32-year-old woman, established patient. (Urology/General Surgery/Internal Medicine/Family Medicine)

Office visit with 63-year-old female, established patient, with familial polyposis, after a previous colectomy and sphincter sparing procedure, now with tenesmus, mucus, and increased stool frequency. (Colon & Rectal Surgery)

Follow-up office visit for a 60-year-old male, established patient, whose post-traumatic seizures have disappeared on medication, and who now raises the question of stopping the medication (Neurology)

**99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a comprehensive history;**
- **a comprehensive examination;**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.





Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

### Examples

Office visit with 30-year-old male, established patient for 3 month history of fatigue, weight loss, intermittent fever, and presenting with diffuse adenopathy and splenomegaly. (Family Medicine)

Office visit for evaluation of recent onset syncopal attacks in a 70-year-old woman, established patient. (Internal Medicine)

Office visit for a 75-year-old established patient with ALS (amyotrophic lateral sclerosis), who is no longer able to swallow. (Neurology)

Office visit for a 70-year-old female, established patient, with diabetes mellitus and hypertension, presenting with a 2 month history of increasing confusion, agitation and short-term memory loss. (Family Medicine/Internal Medicine)

Office visit for restaging of an established patient with new lymphadenopathy one year post-therapy for lymphoma. (Hematology/Oncology)

Office evaluation and discussion of treatment options for a 68-year-old male, established patient, with a biopsy-proven rectal carcinoma. (General Surgery)

Follow-up visit, 40-year-old mother of 3, established patient, with acute rheumatoid arthritis, anatomical Stage 3, ARA function Class 3 rheumatoid arthritis, and deteriorating function. (Rheumatology)

Follow-up office visit for a 65-year-old male, established patient, with a fever of recent onset while on outpatient antibiotic therapy for endocarditis. (Infectious Disease)

## Hospital Observation Services

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Typical times have not yet been established for this category of services.

### OBSERVATION CARE DISCHARGE SERVICES

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

• **99217** Observation care discharge day management
(This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status". To report services to a patient designated as "observation status" who is discharged on the same date, use only the codes for Initial Observation Services (99218-99220))

## INITIAL OBSERVATION CARE

### NEW OR ESTABLISHED PATIENT

The following codes are used to report the encounter(s) by the supervising physician with the patient when designated as "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99241-99245).

To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care (page 26). For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate Initial Hospital Care codes (99221-99223). Do not report observation discharge in conjunction with the hospital admission.

When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting.

Evaluation and management services on the same date provided in sites that are related to initiating "observation status" should NOT be reported separately.

These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical "package." These codes apply to all Evaluation and Management services that are provided on the same date of initiating "observation status."





**99218** Initial observation care, per day, for the evaluation and management of a patient which requires these three key components:

- **a detailed or comprehensive history;**
- **a detailed or comprehensive examination; and**
- **medical decision making that is straightforward or low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to "observation status" are of low severity.

**99219** Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to "observation status" are of moderate severity.

**99220** Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to "observation status" are of high severity.

# Hospital Inpatient Services

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a 'partial hospital' setting. These codes are to be used to report these partial hospitalization services. See also psychiatry notes in the full text of CPT.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines. For hospital observation services, see 99217-99220.

## INITIAL HOSPITAL CARE

### NEW OR ESTABLISHED PATIENT

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in a hospital, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. Evaluation and management services on the same date provided in sites other than the hospital that are related to the admission should NOT be reported separately.

**99221** Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components:

- **a detailed or comprehensive history;**
- **a detailed or comprehensive examination; and**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.





Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

Hospital admission, examination, and initiation of treatment program for a 67-year-old male with uncomplicated pneumonia who requires IV antibiotic therapy. (Internal Medicine)

Hospital admission for a 12-year-old with a laceration of the upper eyelid involving the lid margin and superior canaliculus, admitted prior to surgery for IV antibiotic therapy. (Ophthalmology)

Hospital admission for an 18-month-old child with 10 percent dehydration. (Pediatrics)

Initial hospital visit for a 73-year-old female with acute pyelonephritis who is otherwise generally healthy. (Geriatrics)

Hospital admission for a 32-year-old female with severe flank pain, hematuria and presumed diagnosis of ureteral calculus as determined by Emergency Department physician. (Urology)

Initial hospital visit for a patient with several large venous stasis ulcers not responding to outpatient therapy. (Dermatology)

Initial hospital visit for 21-year-old pregnant patient (9 weeks gestation) with hyperemesis gravidarum. (Obstetrics & Gynecology)

Initial hospital visit for 62-year-old patient with cellulitis of the foot requiring bedrest and intravenous antibiotics. (Orthopaedic Surgery)

**99222** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

Hospital admission, young adult patient, failed previous therapy and now presents in acute asthmatic attack. (Family Medicine/Allergy & Immunology)

Hospital admission of a 62-year-old smoker, established patient, with bronchitis in acute respiratory distress. (Internal Medicine/ Pulmonary Medicine)

Hospital admission, examination, and initiation of a treatment program for a 65-year-old female with new onset of right-sided paralysis and aphasia. (Neurology)

Hospital admission for a 50-year-old with left lower quadrant abdominal pain and increased temperature, but without septic picture. (General Surgery)

Hospital admission, examination, and initiation of treatment program for a 66-year-old chronic hemodialysis patient with fever and a new pulmonary infiltrate. (Nephrology)

Hospital admission for an 8-year-old febrile patient with chronic sinusitis and severe headache, unresponsive to oral antibiotics. (Allergy & Immunology)

Hospital admission for a 3-year-old with high temperature, limp and painful hip motion of 18 hours duration. (Orthopaedic Surgery)

Hospital admission for a 40-year-old male with submaxillary cellulitis and trismus from infected lower molar. (Oral & Maxillofacial Surgery)

**99223** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Hospital admission, examination, and initiation of treatment program for a previously unknown 58-year-old male who presents with acute chest pain. (Cardiology)

Hospital admission following a motor vehicle accident of a 24-year-old male with fracture dislocation of C5-6; neurologically intact. (Neurosurgery)

Hospital admission for a 9-year-old with vomiting, dehydration, fever, tachypnea and an admitting diagnosis of diabetic ketoacidosis. (Pediatrics)

Hospital admission for a 78-year-old female with left lower lobe pneumonia and a history of coronary artery disease, congestive heart failure, osteoarthritis and gout. (Family Medicine)

Initial hospital visit for a 42-year-old female with rapidly progressing scleroderma, malignant hypertension, digital infarcts, and oligourea. (Rheumatology)

Initial hospital visit for 89-year-old female with fulminant hepatic failure and encephalopathy. (Gastroenterology)





Hospital admission, examination, and initiation of treatment program for a 65-year-old immunosuppressed male with confusion, fever, and a headache. (Infectious Disease)

Hospital admission, examination, and initiation of induction chemotherapy for a 42-year-old patient with newly diagnosed acute myelogenous leukemia. (Hematology/Oncology)

Initial hospital visit for a hostile/resistant adolescent patient who is severely depressed and involved in poly-substance abuse. Patient is experiencing significant conflict in his chaotic family situation and was suspended from school following an attack on a teacher with a baseball bat. (Psychiatry)

Initial hospital visit for a 65-year-old male who presents with acute myocardial infarction, oliguria, hypotension, and altered state of consciousness. (Cardiology)

## SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (ie, changes in history, physical condition and response to management) since the last assessment by the physician.

**99231** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Subsequent hospital visit for now stable, 33-year-old male, status post lower gastrointestinal bleeding. (General Surgery)

Subsequent hospital visit for a 50-year-old male with uncomplicated myocardial infarction who is clinically stable and without chest pain. (Family Medicine/Cardiology/Internal Medicine)

Subsequent hospital visit for a 3-year-old patient in traction for a congenital dislocation of the hip. (Orthopaedic Surgery)

Subsequent hospital visit for a 4-year-old female, admitted for acute gastroenteritis and dehydration, requiring IV hydration; now stable. (Family Medicine/Internal Medicine)

Subsequent hospital visit for 50-year-old female with resolving uncomplicated acute pancreatitis. (Gastroenterology)

Subsequent hospital visit for a stable 72-year-old lung cancer patient undergoing a five day course of infusion chemotherapy. (Hematology/Oncology)

Subsequent hospital visit, two days post admission for a 65-year-old male with a CVA (cerebral vascular accident) and left hemiparesis, who is clinically stable. (Neurology/ Physical Medicine and Rehabilitation)

Subsequent visit on third day of hospitalization for a 60-year-old female recovering from an uncomplicated pneumonia. (Infectious Disease/Internal Medicine/Pulmonary Medicine)

**99232** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Subsequent hospital visit for a 54-year-old patient, post MI (myocardial infarction), who is out of the CCU (coronary care unit) but is now having frequent premature ventricular contractions on telemetry. (Cardiology/Internal Medicine)

Subsequent hospital visit for a patient with neutropenia, a fever responding to antibiotics, and continued slow gastrointestinal bleeding on platelet support. (Hematology/Oncology)

Subsequent hospital visit for a 50-year-old male admitted two days ago for sub-acute renal allograft rejection. (Nephrology)

Subsequent hospital visit for a 35-year-old drug addict, not responding to initial antibiotic therapy for pyelonephritis. (Urology)

Subsequent hospital visit for a 73-year-old female with recently diagnosed lung cancer, who complains of unsteady gait. (Pulmonary Medicine)





Subsequent hospital care for a 62-year-old female with congestive heart failure, who remains dyspneic and febrile. (Internal Medicine)

Subsequent hospital visit of a 81-year-old male with abdominal distention, nausea, and vomiting. (General Surgery)

Subsequent hospital visit for a 65-year-old male with hemiplegia and painful paretic shoulder. (Physical Medicine & Rehabilitation)

Subsequent hospital visit for 13-year-old male admitted with left lower quadrant abdominal pain and fever, not responding to therapy. (General Surgery)

Subsequent hospital visit for a 20-month-old male with bacterial meningitis treated 1 week with antibiotic therapy; has now developed a temperature of 101.0. (Pediatrics)

**99233** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- **a detailed interval history;**
- **a detailed examination;**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Subsequent hospital visit for a 55-year-old male with severe chronic obstructive pulmonary disease and bronchospasm; initially admitted for acute respiratory distress requiring ventilatory support in the ICU. The patient was stabilized, extubated and transferred to the floor, but has now developed acute fever, dyspnea, left lower lobe rhonchi and laboratory evidence of carbon dioxide retention and hypoxemia. (Family Medicine/ Internal Medicine)

Subsequent hospital visit for a 60-year-old female with persistent leukocytosis and a fever seven days after a sigmoid colon resection for carcinoma. (Infectious Disease)

Subsequent hospital visit for a patient with AML (acute myelogenous leukemia), fever, elevated white count and uric acid undergoing induction chemotherapy. (Hematology/Oncology)

Subsequent hospital visit for a 38-year-old quadriplegic male with acute autonomic hyperreflexia, who is not responsive to initial care. (Physical Medicine & Rehabilitation)

Subsequent hospital visit for a chronic renal failure patient on dialysis, who develops chest pain, shortness of breath and new onset of pericardial friction rub. (Nephrology)

Subsequent hospital visit for 46-year-old female, known liver cirrhosis patient, with recent upper gastrointestinal hemorrhage from varices; now with worsening ascites and encephalopathy. (Gastroenterology)

Subsequent hospital visit for a 65-year-old male with acute myocardial infarction who now demonstrates complete heart block and congestive heart failure. (Cardiology)

Subsequent hospital visit for a 60-year-old female, 4 days post uncomplicated inferior myocardial infarction who has developed severe chest pain, dyspnea, diaphoresis and nausea. (Family Medicine)

Subsequent hospital visit for a 25-year-old female with hypertension and systemic lupus erythmatosus, admitted for fever and respiratory distress. On the third hospital day, the patient presented with purpuric skin lesions and acute renal failure. (Allergy & Immunology)

Subsequent hospital visit for 62-year-old female admitted with acute subarachnoid hemorrhage, negative cerebral arteriogram, increased lethargy and hemiparesis with fever. (Neurosurgery)

Subsequent hospital visit for a 65-year-old female post-op resection of abdominal aortic aneurysm, with suspected ischemic bowel. (General Surgery)

### HOSPITAL DISCHARGE SERVICES

Final hospital discharge of a patient includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

**99238** Hospital discharge day management

(This code is to be utilized by the physician to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharged on the same date, use only the codes for Initial Hospital Inpatient Services, 99221-99223. To report concurrent care services provided by a physician(s) other than the attending physician, use subsequent hospital care codes (99231-99233) on the day of discharge.) (For Observation Care Discharge, use 99217)

## Consultations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A physician consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in





the patient's medical record and communicated to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate. If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32' or 09932, mandated services, should also be reported.

Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the follow-up consultation codes should not be used. In the hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate inpatient hospital consultation code for the initial encounter and then subsequent hospital care codes (not follow-up consultation codes). In the office setting, the appropriate established patient code should be used.

There are four subcategories of consultations: office, initial inpatient, follow-up inpatient, and confirmatory. See each subcategory for specific reporting instructions.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

### OFFICE OR OTHER OUTPATIENT CONSULTATIONS

#### NEW OR ESTABLISHED PATIENT

The following codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department (See consultation definition, page 32).

Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

**99241** Office consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

### Examples

Office consultation with 25-year-old postpartum female with severe symptomatic hemorrhoids. (Colon & Rectal Surgery)

Office consultation for a 45-year-old male, requested by his internist, with asymptomatic torus palatinus requiring no further treatment. (Oral & Maxillofacial Surgery)

Office consultation with 58-year-old male, referred for follow-up of creatinine level and evaluation of obstructive uropathy, relieved two months ago. (Nephrology)

Office consultation for 30-year-old female tennis player with sprain or contusion of the forearm. (Orthopaedic Surgery)

**99242** Office consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

### Examples

Office consultation for management of systolic hypertension in a 70-year-old male scheduled for elective prostate resection. (Geriatrics)

Office consultation with 27-year-old female, with old amputation, for evaluation of existing above-knee prosthesis. (Physical Medicine & Rehabilitation)





Office consultation for a 30-year-old female with single season allergic rhinitis. (Allergy & Immunology)

Office consultation with 66-year-old female with wrist and hand pain, and finger numbness, secondary to suspected carpal tunnel syndrome. (Orthopaedic Surgery)

Office consultation for a patient with papulosquamous eruption of elbow with pitting of nails and itchy scalp. (Dermatology)

Office consultation for 61-year-old female, recently on antibiotic therapy, now with diarrhea and leukocytosis. (Abdominal Surgery)

**99243** Office consultation for a new or established patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

### Examples

Office consultation for a 65-year-old female with persistent bronchitis. (Infectious Disease)

Office consultation for 25-year-old patient with symptomatic knee pain and swelling, with torn anterior cruciate ligament and/or torn meniscus. (Orthopaedic Surgery)

Office consultation for 39-year-old patient referred at a perimenopausal age for irregular menses and menopausal symptoms. (Obstetrics & Gynecology)

Office consultation for a 65-year-old man with chronic low-back pain radiating to the leg. (Neurosurgery)

Office consultation for 23-year-old female with Crohn's disease not responding to therapy. (Abdominal Surgery/Colon & Rectal Surgery)

Office consultation for a 67-year-old patient with osteoporosis and mandibular atrophy with regard to reconstructive alternatives. (Oral & Maxillofacial Surgery)

**99244** Office consultation for a new or established patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

### Examples

Office consultation for 66-year-old female, history of colon resection for adenocarcinoma 6 years earlier, now with severe mid-back pain; x-rays showing osteoporosis and multiple vertebral compression fractures. (Neurosurgery)

Office consultation with 38-year-old female, with inflammatory bowel disease, who now presents with right lower quadrant pain and suspected intra-abdominal abscess. (General Surgery/Colon & Rectal Surgery)

Office consultation for a patient with long-standing psoriasis with acute onset of erythroderma, pustular lesions, chills and fever. Combinations of topical and systemic treatments discussed and instituted. (Dermatology)

Office consultation with 72-year-old male with esophageal carcinoma, symptoms of dysphagia and reflux. (Thoracic Surgery)

Office consultation for young patient referred by pediatrician because of patient's short attention span, easy distractibility and hyperactivity. (Psychiatry)

Office consultation for a patient with chronic pelvic inflammatory disease who now has left lower quadrant pain with a palpable pelvic mass. (Obstetrics & Gynecology)

Office consultation for discussion of treatment options for a 40-year-old female with a two-centimeter adenocarcinoma of the breast. (Radiation Oncology)

**99245** Office consultation for a new or established patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination;**
- **and medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

### Examples

Office consultation in the emergency room for a 25-year-old male with severe, acute, closed head injury. (Neurosurgery)

Office consultation for adolescent referred by pediatrician for recent onset of violent and self-injurious behavior. (Psychiatry)





Office consultation for a 6-year-old male for evaluation of severe muscle and joint pain and a diffuse rash. Well until 4-6 weeks earlier when he developed arthralgia, myalgias, and a fever of 102° for 1 week. (Rheumatology)

Office consultation for a 27-year-old juvenile diabetic patient with severe diabetic retinopathy, gastric atony, nephrotic syndrome and progressive renal failure, now with a serum creatinine of 2.7, and a blood pressure of 170/114. (Nephrology)

Office consultation for independent medical evaluation of a patient with a history of complicated low back and neck problems with previous multiple failed back surgeries. (Orthopaedic Surgery)

Office consultation for a 23-year-old female with Stage II A Hodgkins disease with positive supraclavicular and mediastinal nodes. (Radiation Oncology)

## INITIAL INPATIENT CONSULTATIONS

### NEW OR ESTABLISHED PATIENT

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one initial consultation should be reported by a consultant per admission.

**99251** Initial inpatient consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Initial inpatient consultation for a 36-year-old male on orthopaedic service with complaint of localized dental pain. (Oral & Maxillofacial Surgery)

Initial inpatient consultation for a 30-year-old female complaining of vaginal itching, post orthopaedic surgery. (Obstetrics & Gynecology)

**99252** Initial inpatient consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Initial inpatient consultation for recommendation of antibiotic prophylaxis for a patient with a synthetic heart valve who will undergo urologic surgery. (Internal Medicine)

Initial inpatient consultation for 66-year-old patient with wrist and hand pain and finger numbness, secondary to carpal tunnel syndrome. (Orthopaedic Surgery/ Plastic Surgery)

Initial inpatient consultation for a 66-year-old male smoker referred for pain management immediately status post-biliary tract surgery done via sub-costal incision. (Anesthesiology/Pain Medicine)

Initial inpatient consultation for possible drug eruption in 50-year-old male. (Dermatology)

Preoperative inpatient consultation for evaluation of hypertension in a 60-year-old male who will undergo a cholecystectomy. Patient had a normal annual check-up in your office four months ago. (Internal Medicine)

Initial inpatient consultation for a 45-year-old male previously abstinent alcoholic, who relapsed and was admitted for management of gastritis. The patient readily accepts the need for further treatment. (Addiction Medicine)

**99253** Initial inpatient consultation for a new or established patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.





### Examples

Initial inpatient consultation for a 57-year-old male, post lower endoscopy, for evaluation of abdominal pain and fever. (General Surgery)

Initial inpatient consultation for diagnosis/management of fever following abdominal surgery. (Internal Medicine)

Initial inpatient consultation for a 42-year-old non-diabetic patient, post-op cholecystectomy, now with an acute urinary tract infection. (Nephrology)

Initial inpatient consultation for 8-year-old patient with new onset of seizures who has a normal examination and previous history. (Neurology)

Initial inpatient consultation for rehabilitation of a 73-year-old female one week after surgical management of a hip fracture. (Physical Medicine & Rehabilitation)

Initial inpatient consultation for a 35-year-old female with a fever and pulmonary infiltrate following caesarean section. (Pulmonary Medicine)

Initial inpatient consultation for 53-year-old female with moderate uncomplicated pancreatitis. (Gastroenterology)

Initial inpatient consultation for 45-year-old patient with chronic neck pain with radicular pain of the left arm. (Orthopaedic Surgery)

**99254** Initial inpatient consultation for a new or established patient, which requires three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Initial inpatient consultation for a 72-year-old male with emergency admission for possible bowel obstruction. (Internal Medicine/ General Surgery)

Initial inpatient consultation for a 43-year-old female for evaluation of sudden painful visual loss, optic neuritis and episodic paresthesia. (Ophthalmology)

Initial inpatient consultation for a 66-year-old female with enlarged supraclavicular lymph nodes, found on biopsy to be malignant. (Hematology/Oncology)

Initial inpatient consultation for a 35-year-old female with fever, swollen joints, and rash of 1 week duration. (Rheumatology)

Initial inpatient consultation for evaluation of a 63-year-old in the ICU with diabetes and chronic renal failure who develops acute respiratory distress syndrome 36 hours after a mitral valve replacement. (Anesthesiology)

Initial inpatient consultation for evaluation of a 71-year-old male with hyponatremia (serum sodium 114) who was admitted to the hospital with pneumonia. (Nephrology)

**99255** Initial inpatient consultation for a new or established patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Initial inpatient consultation in the ICU for a 70-year-old male who experienced a cardiac arrest during surgery and was resuscitated. (Cardiology)

Initial inpatient consultation for a patient with severe pancreatitis complicated by respiratory insufficiency, acute renal failure and abscess formation. (Gastroenterology)

Initial inpatient consultation for a 70-year-old cirrhotic male admitted with ascites, jaundice, encephalopathy, and massive hematemesis. (Gastroenterology)

Initial inpatient consultation in the ICU for a 51-year-old patient who is on a ventilator and has a fever two weeks after a renal transplantation. (Infectious Disease)

Initial inpatient consultation for a 50-year-old male with a history of previous myocardial infarction, now with acute pulmonary edema and hypotension. (Cardiology)

Initial inpatient consulation for evaluation and formulation of plan for management of multiple trauma patient with complex pelvic fracture, 35-year-old male. (General Surgery/ Orthopaedic Surgery)

Initial inpatient consultation for 36-year-old female referred by her internist to evaluate a patient being followed for abdominal pain and fever. The patient has developed diffuse abdominal pain, guarding, rigidity and increased fever. (Obstetrics & Gynecology)

Initial inpatient consultation for 45-year-old male with recent, acute subarachnoid hemorrhage, hesitant speech, mildly confused, drowsy. High risk group for HIV+ status. (Neurosurgery)





## FOLLOW-UP INPATIENT CONSULTATIONS

### ESTABLISHED PATIENT

Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician.

A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.

If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (99231-99233).

The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (99241-99245).

**99261** Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Follow-up inpatient consultation with 35-year-old female with pulmonary embolism post-op cesarean section, now stable, for assessment of response to anticoagulation and recommended adjustment of heparin dose. (Pulmonary Medicine)

Follow-up inpatient consultation for a 74-year-old male whose postoperative facial paralysis after a cholecystectomy is now resolving. (Neurology)

Follow-up inpatient consultation for a 36-year-old female 2 days after spontaneous passage of 3mm stone. (Urology)

Follow-up inpatient consultation for a 94-year-old male nursing home resident for re-evaluation of hemorrhoids following conservative therapy. (Colon & Rectal Surgery/ General Surgery/Geriatrics)

Follow-up inpatient consultation with 67-year-old female, established patient for review of diagnostic studies ordered at time of first contact. (Internal Medicine)

Follow-up inpatient consultation for a 50-year-old male, asymptomatic with borderline ECG abnormality, needs preoperative opinion after a thallium exercise perfusion scan. (Cardiology)

Follow-up inpatient consultation for 78-year-old female nursing home resident for evaluation of medical management of pruritis ani. (General Surgery/Colon & Rectal Surgery)

**99262** Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Follow-up inpatient consultation with 72-year-old female, established patient with bullous pemphigoid on combined oral therapy steroids and immunosuppressive to evaluate progress of cutaneous care orders and adjustment of oral/parenteral therapy dosages. (Dermatology)

Follow-up inpatient consultation with 68-year-old, incapacitated male, with spinal stenosis and failure to respond to bedrest, analgesics, and PT. (Neurosurgery)

Follow-up inpatient consultation for reevaluation of a stroke patient, and development of plan for initial rehabilitation services. (Neurology)

Follow-up inpatient consultation for an asymptomatic 35-year-old Type I diabetic patient with hyperkalemic, hyperchloremia acidosis, to review lab results. (Nephrology)

Follow-up inpatient consultation for a 71-year-old male who has developed a maculopapular skin rash while on antibiotics that you recommended for an uncomplicated pneumonia. (Infectious Disease)

Follow-up inpatient consultation with 51-year-old male, for evaluation and determination of the etiology of postoperative hyponatremia following TURP. (Family Medicine)

Follow-up inpatient consultation with 45-year-old male, established patient for discussion of CT scan which demonstrates a cavernous hemangioma. (Ophthalmology)

Follow-up inpatient consultation for an elderly male with a perioperative myocardial infarction requiring adjustment of vasoactive medications. (Anesthesiology)





**99263** Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- **a detailed interval history;**
- **a detailed examination;**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

Follow-up inpatient consultation with 72-year-old male established patient admitted for management of alcohol withdrawl, now confused and febrile. (Addiction Medicine)

Follow-up inpatient consultation with 58-year-old diabetic female, with bacterial endocarditis, continued fever after 2 weeks of intravenous antibiotic therapy, and new onset ventricular ectopia. (Cardiology)

Follow-up inpatient consultation for 42-year-old male with persistent gastrointestinal bleeding, etiology undetermined, not responding to conservative therapy of transfusions. (General Surgery/Colon & Rectal Surgery)

Follow-up inpatient consultation for a 62-year-old male, status post-op acute small bowel obstruction; now with acute renal failure. (Family Medicine)

Follow-up inpatient consultation for an HIV-positive patient with an increasing fever following ten days of antibiotic therapy for pneumocystis carinii pneumonia. (Infectious Disease)

Follow-up inpatient consultation for a 90-year-old female with urinary incontinence who has a complicated medical history requiring reassessment of multiple medical problems, recommendations for placement, further recommendation for management of incontinence and reevaluation of cognitive status because of competency issues. (Geriatrics/Psychiatry)

Follow-up inpatient consultation for a 62-year-old female with steroid-dependent asthma, diabetes mellitus, thyrotoxicosis, abdominal pain and possible vasculitis. (Rheumatology)

## CONFIRMATORY CONSULTATIONS

### NEW OR ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure).

Confirmatory consultations may be provided in any setting.

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32' or 09932, mandated services, should also be reported.

(See also Consultation notes, page 32).

Typical times have not yet been established for this subcategory of services.

**99271** Confirmatory consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

**99272** Confirmatory consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**99273** Confirmatory consultation for a new or established patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of low complexity.**





Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**99274** Confirmatory consultation for a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

**99275** Confirmatory consultation for a patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

# Emergency Department Services

## NEW OR ESTABLISHED PATIENT

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For critical care services provided in the Emergency Department, see Critical Care notes and 99291, 99292.

For evaluation and management services provided to a patient in an observation area of a hospital, see 99217-99220.

For definitions of key components and commonly used terms, see Evaluation and Management Services Guidelines.

**99281** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

**Examples**

Emergency department visit for a patient for removal of sutures from a well-healed, uncomplicated laceration. (Emergency Medicine)

Emergency department visit for a patient for tetanus toxoid immunization. (Emergency Medicine)

Emergency department visit for a patient with several uncomplicated insect bites. (Emergency Medicine)

**99282** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity.



**Examples**

Emergency department visit for a child presenting with impetigo localized to the face. (Emergency Medicine)

Emergency department visit for a 20-year-old student who presents with a painful sunburn with blister formation on the back. (Emergency Medicine)

Emergency department visit for a young adult patient with infected sclera and purulent discharge from both eyes without pain, visual disturbance or history of foreign body in either eye. (Emergency Medicine)

Emergency department visit for an otherwise healthy patient whose chief complaint is a red, swollen cystic lesion on his/her back. (Emergency Medicine)

Emergency department visit for a patient presenting with a rash on both legs after exposure to poison ivy. (Emergency Medicine)

Emergency department visit for a patient with a minor traumatic injury of an extremity with localized pain, swelling, and bruising. (Emergency Medicine)

**99283** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**Examples**

Emergency department visit for a sexually active female complaining of vaginal discharge who is afebrile and denies experiencing abdominal or back pain. (Emergency Medicine)

Emergency department visit for a well-appearing 8-year-old child who has a fever, diarrhea and abdominal cramps, is tolerating oral fluids and is not vomiting. (Emergency Medicine)

Emergency department visit for a patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle. (Emergency Medicine)

Emergency department visit for a patient who has a complaint of acut pain associated with a suspected foreign body in the painful eye. (Emergency Medicine)

Emergency department visit for a healthy, young adult patient who sustained a blunt head injury with local swelling and bruising without subsequent confusion, loss of consciousness or memory deficit. (Emergency Medicine)

**99284** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

### Examples

Emergency department visit for a 4-year-old child who fell off a bike sustaining a head injury with brief loss of consciousness. (Emergency Medicine)

Emergency department visit for an elderly female who has fallen and is now complaining of pain in her right hip and is unable to walk. (Emergency Medicine)

Emergency department visit for a female presenting with lower abdominal pain and a vaginal discharge. (Emergency Medicine)

Emergency department visit for a patient with flank pain and hematuria. (Emergency Medicine)

**99285** Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

### Examples

Emergency department visit for a patient exhibiting active, upper gastrointestinal bleeding. (Emergency Medicine)

Emergency department visit for a patient with a new onset of rapid heart rate requiring IV drugs. (Emergency Medicine)





Emergency department visit for a previously healthy young adult patient who is injured in an automobile accident and is brought to the emergency department immobilized and has symptoms compatible with intra-abdominal injuries or multiple extremity injuries. (Emergency Medicine)

Emergency department visit for a patient with an acute onset of chest pain compatible with symptoms of cardiac ischemia and/or pulmonary embolus. (Emergency Medicine)

Emergency department visit for a patient with a new onset of a cerebral vascular accident. (Emergency Medicine)

Emergency department visit for a patient with a complicated overdose requiring aggressive management to prevent side effects from the ingested materials. (Emergency Medicine)

Emergency department visit for a patient who presents with a sudden onset of "the worst headache of her life," and complains of a stiff neck, nausea, and inability to concentrate. (Emergency Medicine)

Emergency department visit for acute febrile illness in an adult, associated with shortness of breath and an altered level of alertness. (Emergency Medicine)

## MISCELLANEOUS

In physician directed emergency care, advanced life support, the physician is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital. The physician directs the performance of necessary medical procedures, including but not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or administration of intramuscular, intratracheal or subcutaneous drugs; and/or electrical conversion of arrhythmia.

**99288** Physician direction of emergency medical systems (EMS) emergency care, advanced life support

# Critical Care Services

Critical care includes the care of critically ill or injured patients in a variety of medical emergencies that requires the constant attendance of the physician (eg, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using subsequent hospital care codes (see 99231-99233) or hospital consultation codes (see 99251-99263) as appropriate.

The following services are included in reporting critical care when performed during the critical period by the physician providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71020), blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data (99090)); gastric intubation (91105); temporary transcutaneous pacing (92953); ventilator management (94656, 94657, 94660, 94662); and, vascular access procedures (36000, 36410, 36415, 36600). Any services performed which are not listed above should be reported separately.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill or injured patient, even if the time spent by the physician providing critical care services on that date is not continuous. Code 99291 is used to report the first hour of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code. Code 99292 is used to report each additional 30 minutes beyond the first hour. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

The following examples illustrate the correct reporting of critical care services:

| Total Duration of Critical Care | Codes |
|---|---|
| a. less than 30 minutes (less than 1/2 hour) | 99232 or 99233 |
| b. 30-74 minutes (1/2 hr. - 1 hr. 14 min.) | 99291 X 1 |
| c. 75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.) | 99291 X 1 AND 99292 X 1 |
| d. 105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.) | 99291 X 1 AND 99292 X 2 |
| e. 135 - 164 minutes (2 hr. 15 min. - 2 hr. 44 min.) | 99291 X 1 AND 99292 X 3 |
| f. 165 - 194 minutes (2 hr. 45 min. - 3 hr. 14 min.) | 99291 X 1 AND 99292 X 4 |

**99291** Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour





**99292** each additional 30 minutes

## Neonatal Intensive Care

The following codes (99295-99297) are used to report services provided by a physician directing the care of a neonate or infant in a neonatal intensive care unit (NICU). They represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered to be critically ill, the codes for Subsequent Hospital Care (99231-99233) should be utilized.

These NICU codes are to be used in addition to codes 99354, 99357 and 99440 when the physician is present for the delivery and newborn resuscitation is required.

Care rendered includes management; monitoring and treatment of the patient including nutritional, metabolic and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

The following procedures are also included as part of the global descriptors: umbilical, central or peripheral vessel catheterization, endotracheal intubation, lumbar puncture and suprapubic bladder aspiration. In addition, specific services are included in the parenthetic note following each NICU code. Any services performed which are not listed above or not listed with each NICU code should be reported separately.

(For additional instructions, see parenthetical descriptions listed for 99295-99297)

**99295** Initial NICU care, per day, for the evaluation and management of a critically ill neonate or infant

This care is provided on the date of admission of a neonate who requires cardiopulmonary monitoring and support. Such care includes the following, as necessary: initiation of mechanical ventilation or continuous positive airway pressure (CPAP); surfactant administration; pharmacologic control of the circulatory system; intravascular fluid administration; transfusion of blood components; vascular punctures; and blood gas interpretation.

**99296** Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant

A critically ill and unstable neonate represents a neonate whose cardiopulmonary and metabolic status is unstable; whose neurologic status may be unstable; who requires frequent ventilator changes, inotropic and chronotropic support; who requires frequent IV changes and whose condition is changing almost minute to minute. Such an infant requires almost constant attention by a physician.

This description represents care provided on dates subsequent to the admission date. Such care includes the following, as necessary: mechanical ventilation or CPAP; surfactant administration; pharmacologic control of the circulatory system; total parenteral nutrition; seizure management; invasive or non-invasive electronic monitoring of vital signs, and/or monitoring of blood gases or oxygen saturation.

**99297** Subsequent NICU care, per day, for the evaluation and management of a critically ill and stable neonate or infant

A critically ill and stable neonate may represent an infant who is still intubated and requires invasive cardiopulmonary monitoring but whose vital signs are stable; who is not seizing; whose metabolic status is stable but who is still NPO and receiving parenteral nutrition and IV medications; and who is not yet over the acute phase of the initial problem.

This description represents care provided on dates subsequent to the admission date. Such care includes the following, as necessary: ventilatory support and treatment; total parenteral nutrition; invasive or non-invasive electronic monitoring of vital signs; apnea management and/or monitoring of blood gases or oxygen saturation.

# Nursing Facility Services

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24 hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.





Nursing facilities that provide convalescent, rehabilitative, or long term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs trigger the identification of potential problems and provide guidelines for follow-up assessments.

Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning.

Two subcategories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients. Comprehensive Assessments may be performed at one or more sites in the assessment process: the hospital, observation unit, office, nursing facility, domiciliary/non-nursing facility or patient's home.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

## COMPREHENSIVE NURSING FACILITY ASSESSMENTS

### NEW OR ESTABLISHED PATIENT

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, physician's office), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed as part of the admission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting. With the exception of hospital discharge services, evaluation and management services on the same date provided in sites other than the nursing facility that are related to the admission should NOT be reported separately. Hospital discharge services may be reported separately.

More than one comprehensive assessment may be necessary during an inpatient confinement.

**99301** Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components:

- **a detailed interval history;**
- **a comprehensive examination; and**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

**99302** Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components:

- **a detailed interval history;**
  **a comprehensive examination; and**
- **medical decision making of moderate to high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.

**99303** Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate to high complexity.**





Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.

## SUBSEQUENT NURSING FACILITY CARE

### NEW OR ESTABLISHED PATIENT

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

**99311** Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

**99312** Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

**99313** Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- **a detailed interval history;**
- **a detailed examination;**
- **medical decision making of moderate to high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

## Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Typical times have not yet been established for this category of services.

### NEW PATIENT

**99321** Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making that is straightforward or of low complexity.**





Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**99322** Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**99323** Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high complexity.

### ESTABLISHED PATIENT

**99331** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**99332** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

**99333** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a detailed interval history;**
- **a detailed examination;**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

## Home Services

The following codes are used to report evaluation and management services provided in a private residence.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines. Typical times have not yet been established for this category of services.

### NEW PATIENT

**99341** Home visit for the evaluation and management of a new patient, which requires these three key components:



- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**99342** Home visit for the evaluation and management of a new patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**99343** Home visit for the evaluation and management of a new patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity.

### ESTABLISHED PATIENT

**99351** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**99352** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

**99353** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **a detailed interval history;**
- **a detailed examination;**
- **medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

# Prolonged Services

## PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT

Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period.



Codes 99354-99357 are used to report the total duration of face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continous.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. Either code should be used only once per date, even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

The following examples illustrate the correct reporting of prolonged physician service with direct patient contact in the office setting:

| Total Duration of Prolonged Services | Code(s) |
|---|---|
| a. less than 30 minutes (less than 1/2 hour) | Not reported separately |
| b. 30-74 minutes (1/2 hr. - 1 hr. 14 min.) | 99354 X 1 |
| c. 75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.) | 99354 X 1 AND 99355 X 1 |
| d. 105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.) | 99354 X 1 AND 99355 X 2 |
| e. 135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.) | 99354 X 1 AND 99355 X 3 |
| f. 165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.) | 99354 X 1 AND 99355 X 4 |

- **99354** Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour
- **99355** each additional 30 minutes

• **99356** Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour

• **99357** each additional 30 minutes

### PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT

Codes 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual service in either the inpatient or outpatient setting. This service is to be reported in addition to other physician service, including evaluation and management service at any level.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous. Code 99358 is used to report the first hour of prolonged sevice on a given date regardless of the place of service.

It may also be used to report a total duration of prolonged service of 30-60 minutes on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15-30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

• **99358** Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour

• **99359** each additional 30 minutes

(To report telephone calls, see 99371-99373)





### PHYSICIAN STANDBY SERVICE

Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may not be providing care or service to other patients during this period. This code is not used to report time spent proctoring another physician. It is also not used if the period of standby ends with the performance of a procedure subject to a "surgical package" by the physician who was on standby.

Code 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

• **99360** Physician standby service, requiring prolonged physician attendance; each 30 minutes (eg, operative standby, standby cesarean/high risk delivery for newborn care)

## Case Management Services

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

### TEAM CONFERENCES

**99361** Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes

**99362** approximately 60 minutes

### TELEPHONE CALLS

**99371** Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)

**99372** intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)

**99373** complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)

## Care Plan Oversight Services

Care Plan Oversight Services are reported separately from codes for office/outpatient, hospital, home, nursing facility or domiciliary services. The complexity and approximate physician time of the care plan oversight services provided within a 30-day period determine code selection. Only one physician may report services for a given period of time, to reflect that physician's sole or predominant supervisory role with a particular patient. These codes shuld not be reported for supervision of patients in nursing facilities or under the care of home health agencies unless they require recurrent supervision of therapy.

The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes.

Care plan oversight services provided which are less than 30 minutes during a 30-day period are considered part of patient evaluation and management and should not be reported separately.

• **99375** Physician supervision of patients under care of home health agencies, hospice or nursing facility patients (patient not present) requiring complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a 30-day period; 30-60 minutes

• **99376** greater than 60 minutes





## Preventive Medicine Services

The following codes are used to report the routine evaluation and management of adults and children when these services are performed in the absence of patient complaints. The extent and focus of the services will largely depend on the age of the patient, the circumstances of the examination, and the abnormalities encountered.

Codes 99381-99397 do not include counseling, risk factor reduction interventions or immunizations. If risk management services are provided at the same session as a preventive medicine visit, both codes should be reported. For counseling and/or risk factor reduction interventions, see 99401-99412. For immunizations, see 90701-90749.

Ancillary studies involving laboratory, radiology, or other procedures are reported separately.

### NEW PATIENT

**99381** Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)

**99382** early childhood (age 1 through 4 years)

**99383** late childhood (age 5 through 11 years)

**99384** adolescent (age 12 through 17 years)

**99385** 18-39 years

**99386** 40-64 years

**99387** 65 years and over

### ESTABLISHED PATIENT

**99391** Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)

**99392** early childhood (age 1 through 4 years)

**99393** late childhood (age 5 through 11 years)

**99394** adolescent (age 12 through 17 years)

**99395** 18-39 years

**99396** 40-64 years

**99397** 65 years and over

### COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION

#### NEW OR ESTABLISHED PATIENT

These codes are used to report services provided to healthy individuals for the purpose of promoting health and preventing illness or injury.

Counseling and risk factor reduction interventions provided in conjunction with an initial or periodic preventive medicine visit will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention and dental health.

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital or consultation or other evaluation and management codes. For counseling groups of patients with symptoms or established illness, use 99078.

#### PREVENTIVE MEDICINE, INDIVIDUAL COUNSELING

**99401** Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes

**99402** approximately 30 minutes

**99403** approximately 45 minutes

**99404** approximately 60 minutes

#### PREVENTIVE MEDICINE, GROUP COUNSELING

**99411** Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes

**99412** approximately 60 minutes

#### OTHER PREVENTIVE MEDICINE SERVICES

**99420** Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)

**99429** Unlisted preventive medicine service





## Newborn Care

The following codes are used to report the services provided to normal or high risk newborns in several different settings. For hospital discharge services, use 99238.

**99431** History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

**99432** Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)

**99433** Subsequent hospital care, for the evaluation and management of a normal newborn, per day

(99438 has been deleted)

**99440** Newborn resuscitation: care of the high risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization

## Other Evaluation and Management Services

**99499** Unlisted evaluation and management service

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Nancy K. Edwards, MA
Grace M. Kotowicz, RN, BS
Gina Leoni, RRA
Yolanda Malone, BS
Mary R. McNamara O'Heron, RRA
Belinda R. Mosley
Karen E. O'Hara, BS
Mary A. Riesbeck, BA
Karen R. Scholten
Maurine G. Spillman, MPH

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Karen R. Scholten

Library of Congress Catalog Card Number: 78-13816

ISBN: 0-89970-556-1
ISSN: 0276-8283



1st Edition printed 1966
2nd Edition printed 1970
3rd Edition printed 1973
4th Edition printed 1977
revised: 1978, 1979, 1980, 1981
reprinted: 1980, 1982
CPT-1984—First printing, November 1983
Second printing, January 1984
Third printing, June 1984
Fourth printing, September 1984
CPT-1985—First printing, November 1984
Second printing, January 1985
CPT-1986—First printing, November 1985
Second printing, February 1986
Third printing, August 1986
CPT-1987—First printing, November 1986
Second printing, April 1987
Third printing, July 1987
CPT-1988—First printing, November 1987
Second printing, January 1988
Third printing, March 1988
Fourth printing, April 1988
CPT-1989—First printing, November 1988
Second printing, February 1989
Third printing, April 1989
CPT-1990—First printing, November 1989
CPT-1991—First printing, November 1990
CPT-1992—First printing, October 1991
CPT-1993—First printing, October 1992
CPT-1994—First printing, September, 1993

For other correspondence address inquiries to:
Department of Coding & Nomenclature
American Medical Association
515 North State Street
Chicago, IL 60610

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Order Department: OP054194HA
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AC22:93-481-425MM:9/93



# Foreword

Physicians' *Current Procedural Terminology,* Fourth Edition (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties. CPT 1994 is the most recent revision of a work that first appeared in 1966.

CPT descriptive terms and identifying codes currently serve a wide variety of important functions in the field of medical nomenclature. This system of terminology is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs. CPT is also useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review. The uniform language is likewise applicable to medical education and research by providing a useful basis for local, regional, and national utilization comparisons.

The changes that appear in this revision have been prepared by the CPT Editorial Panel with the assistance of physicians representing all specialties of medicine, and with important contributions from many third party payors and governmental agencies.

With the introduction of new codes for evaluation and management services in CPT 1992, important changes were made in the way that physicans report many of their services. These revisions were responsive to changes in the medical practice environment. Further experience with the use of these new codes provides strong evidence that this new system will provide greater uniformity, will be easier for physicians to use, and will be flexible enough to accommodate additional medical practice changes for many years.

As we continue to gain experience with the new system, we continue to expect that there will be a period of adjustment and continued refinement. This period will require efforts by both physicians and by third party payors to learn and adapt to the concepts inherent in the new system.

The American Medical Association trusts that this revision will continue the usefulness of its predecessors in identifying, describing, and coding medical, surgical, and diagnostic services performed by practicing physicians.

James S. Todd, M.D.
Executive Vice President

October 1, 1993



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# Acknowledgements

The publication of CPT 1994 represents a product of the combined efforts of many individuals and organizations. The editors accordingly express their gratitude to the many national medical specialty societies, state medical associations, health insurance organizations and agencies, and to the many individual physicians who devoted their energies and expertise to the preparation of this revision. Thanks are due to Jean A. Harris, Health Care Financing Administration, Bonnie Balkin and David Tennenbaum, Blue Cross and Blue Shield Association, Thomas Musco, Health Insurance Association of America, Donna Pickett, American Hospital Association, and to Toula Nicholas, American Health Information Management Association, for their invaluable assistance in enhancing CPT. Finally, the editors are grateful to Barry S. Eisenberg, Director, Division of Payment Policy and Programs, for his helpful invaluable assistance.

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